

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

- 07/98 or serious dysfunction of any bodily organ part. The determination of the level of service reimbursable by the Department shall be based upon the circumstances at the time of the initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.
- 07/98 1. Emergency Level I refers to Emergency Services provided in the hospital's emergency department for the alleviation of severe pain or for immediate diagnosis or treatment of conditions or injuries which pose an immediate significant threat to life or physiologic function.
- 07/98 2. Emergency Level II refers to Emergency Services that do not meet the above definition of Emergency Level I care, but which are provided in the hospital emergency department for a medical condition manifesting itself by acute symptoms of sufficient severity.
- 07/98 3. Non-Emergency/Screening Level means those services provided in the hospital emergency department that do not meet the requirements of Emergency Levels I or II stated above. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided or a screening fee, but not both. The reimbursement rate for the screening fee will be the same as the current applicable rate for procedure code 99282 (emergency department visit, as specified in the Physicians Current Procedural Terminology, fourth edition [CPT-4]).

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Supersedes

TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

- 07/98 D. Group 4 for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. The hospital may bill for both observation and other APL procedures but will be reimbursed only for the procedure (group) with the highest reimbursement rate. Observation services will be reimbursed under one of three categories: at least one hour but less than six hours and thirty-one minutes of services; at least six hours and thirty-one minutes but less than twelve hours and thirty-one minutes of services; or, twelve hours and thirty-one minutes of services or more.
- ~~Group IV procedures are specialized treatment procedures, observation services, high risk, and emergency room services.~~
- 07/98 E. Group 5 for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services. Under this group, the Department will reimburse Type A and Type B Psychiatric Clinic Services, as defined in the Illinois Administrative Code at 89 Ill. Adm. Code Section 148.40.d..2. and the Illinois Medicaid State Plan.
- 07/98 F. Group 6 for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services that are provided by a hospital that is enrolled with the Department to provide inpatient physical rehabilitation services.
- 07/98 ii. ~~Hospital Ambulatory Care List Updating~~
 ~~The Hospital Ambulatory Care list is updated periodically. As technology changes, so do the procedures that fall into the four categories. In addition, annual changes in the ICD-9-CM procedure codes and their meanings necessitate annual changes to the Hospital Ambulatory Care list.~~

TN # 98-14

APPROVAL DATE OCT 26 1998 EFFECTIVE DATE 07-01-98

Supersedes
TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

- 07/98 ii. Each of the groups above will be reimbursed by the Department considering the following:
- 07/98 A. With the exception of county-owned hospitals located in an Illinois county with a population greater than three million, ~~and hospitals not required to file an annual cost report with the Department~~, reimbursement rates for each of the reimbursement groups described above shall be the lesser of:
- 07/98 1. the hospital's charge to the general public, or
- 07/98 2. rates established by the Department.
- 07/98 B. APL rates established by the Department, as stated in subsection b.ii.A.2 of this subsection, will be based on a relative weighting of each reimbursement grouping. The relative weighting of each group will be based on the resource intensity required to provide service described under each group. Classifications of procedures into APL groups will be reviewed annually and relative weighting will be updated periodically.
- 07/98 C. For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amount described in subsection B. above, multiplied by a factor of two. However, such rates shall be no lower than the rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 07/98 D. The rate for each group is all-inclusive for services provided by the hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. The one exception is that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional services of physicians who are salaried by the hospital and who provide emergency Level I or II services in the emergency department. For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of

TN # 98-14

APPROVAL DATE OCT 26 1999 EFFECTIVE DATE 07-01-98

Supersedes
TN # _____

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

07/98

E.

physicians with a financial contract to provide emergency department care.

The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting. All groups that may be reimbursed to an ASCT are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facility services, which shall be 75 percent of the applicable APL rate.

1. Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:

- a. Nursing, technician and related services;
- b. Use of the ASTC facilities;
- c. Supplies (such as drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures;
- d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- e. Administrative, record keeping, and housekeeping items and services; and
- f. Materials for anesthesia.

2. Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.

07/98

~~iii. Hospital Ambulatory Care Reimbursement Prior to July 1, 1995~~

TN # 98-14

APPROVAL DATE OCT 26 1999

EFFECTIVE DATE 07-01-98

Supersedes

TN # _____

State Illinois

- 07/98 iii. ~~The assignment of procedure codes to each of the reimbursement groups in subsection b.4 i. of this Section are detailed in the Department's Hospital Handbook and in notices to providers.~~
- 07/98 ~~Reimbursement for Hospital Ambulatory Care procedures was initially developed in 1986. For each of the four separate groupings identified on the prior page, a set rate maximum was developed based upon the complexity of the procedures, historical costs, the teaching status of the hospital, the type of hospital, and the setting in which the procedure would most likely be performed (i.e., outpatient and significantly less than reimbursement for department, general clinic department, psychiatric clinic department, or rehabilitation clinic department). These set rate maximums have been periodically adjusted since 1986 based upon the above factors and remain significantly less than the costs of providing the services comparable services provided under comparable circumstances under the Medicare Program. Reimbursement for Hospital Ambulatory Care procedures performed prior to July 1, 1995, shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~
- 07/98 iv. ~~Hospital Ambulatory Care Reimbursement Effective July 1, 1995:~~
- 07/98 ~~Effective July 1, 1995, reimbursement for Hospital Ambulatory Care procedures shall be as follows:~~
- 07/98 1. ~~With respect to the Group I procedures described in Section 1.b.i.A. of this Chapter, reimbursement shall be at the lesser of charges or the hospital's alternate reimbursement rate, as defined in Chapter VIII, Section B of State Plan Amendment 4.19A, equivalent to the rate of a one-day inpatient stay.~~

TN # 98-14

APPROVAL DATE OCT 26 1999 EFFECTIVE DATE 07-01-98

Supersedes

TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

- 07/98 2. With respect to the Group II procedures described in Section 1.b.i.B. of this Chapter, reimbursement shall be at the lesser of charges or one of two separate rate maximums as follows:
- 07/98 a. In the case of a hospital defined in Appendix to Attachments 3.1 A and B, Chapters 2a.9.a.1. through 3., which is a major teaching hospital, as defined in State Plan Amendment 4.19A, Chapter XVI, Section A.4, or a children's hospital, as defined in State Plan Amendment 4.19A, Chapter II, Section C.3., \$258.75; or
- 07/98 b. In the case of a hospital defined in State Plan Amendment 4.19A, Chapter XVI, Section A.1., \$230.00.
- 07/98 3. With respect to the Group III procedures described in Section 1.b.i.C. of this Chapter, reimbursement shall be at the lesser of charges or one of two separate rate maximums as follows:
- 07/98 a. In the case of a hospital defined in Appendix to Attachments 3.1 A and B, Chapters 2a.9.a.1. through 3., which is a major teaching hospital, as defined in State Plan Amendment 4.19A, Chapter XVI, Section A.4, or a children's hospital, as defined in State Plan Amendment 4.19A, Chapter II, Section C.3., \$201.25; or
- 07/98 b. In the case of a hospital defined in State Plan Amendment 4.19A, Chapter XVI, Section A.1., \$161.00.
- 07/98 4. With respect to the Group IV procedures described in Section 1.b.i.D. of this Chapter, reimbursement shall be at the lesser of charges or one of six separate rate maximums as follows:

TN # 98-14

APPROVAL DATE OCT 26 1999

EFFECTIVE DATE 07-01-98

Supersedes
TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

07/98

- a. ~~In the case of a hospital defined in Appendix to Attachments 3.1 A and B, Chapters 2a.9.a.1. through 3., which is a major teaching hospital, as defined in State Plan Amendment 4.19A, Chapter XVI, Section A.4, or a children's hospital, as defined in State Plan Amendment 4.19A, Chapter II, Section C.3.:~~
- i. ~~\$132.25 when the service is provided in the outpatient department of the hospital.~~
 - ii. ~~\$120.75 when the service is provided in the general clinic department of the hospital.~~
 - iii. ~~\$102.35 when the service is provided in the psychiatric or rehabilitation clinic department of the hospital.~~

07/98

- b. ~~In the case of a hospital defined in State Plan Amendment 4.19A, Chapter XVI, Section A.1.:~~
- i. ~~\$115.00 when the service is provided in the outpatient department of the hospital.~~
 - ii. ~~\$92.00 when the service is provided in the general clinic department of the hospital.~~
 - iii. ~~\$62.10 when the service is provided in the psychiatric or rehabilitation clinic department of the hospital.~~

07/98

iv. Outpatient Indigent Volume Adjustment Payment

- A. Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois County with a population of over three million shall be eligible for an outpatient indigent volume adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Chapter and are calculated as follows:

TN # 98-14APPROVAL DATE OCT 26 1999EFFECTIVE DATE 07-01-98Supersedes
TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

- 07/95 B. In order to ensure funding for the outpatient indigent volume adjustment payment, an indigent pool shall be created. The amount of money dedicated to this pool shall equal \$200 million.
- 07/95 C. Payments from the indigent pool, to individual eligible hospitals, shall be in an amount that is in proportion to the number of Medicaid outpatient services (as identified on claims submitted to the Illinois Department of Public Aid for payment) that the individual hospital provided to persons eligible for Medicaid divided by the total of all Medicaid outpatient services provided to persons eligible for Medicaid by all hospitals eligible to receive outpatient indigent volume adjustment payments. The service statistics used in this calculation shall reflect services provided during the most recently completed State fiscal year prior to the State fiscal year in which the payments are being made (SFY'94 utilization statistics for payments made in SFY'96). Payments under this subsection shall be made on a quarterly basis.
- 07/95 D. Aggregate Medicaid reimbursement for all hospitals for Medicaid outpatient services (including outpatient indigent volume adjustment reimbursement) will not be allowed to exceed total allowable Medicaid outpatient costs for Medicaid outpatient services provided to Illinois Medicaid recipients. This test will be made annually. If the test against the upper limit finds that the upper limit was exceeded, the size of the outpatient indigent volume adjustment pool will be reduced by the amount in excess of the limit.
- 07/98 ~~v. -vi.~~ No Year-End Reconciliation
- 07/95 With the exception of the retrospective rate adjustment described in ~~1-b.vii.~~ 1.b.vi. of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1.b.

TN # 98-14APPROVAL DATE OCT 26 1999EFFECTIVE DATE 07-01-98Supersedes
TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

07/98 vii. Rate Adjustments

07/95 With respect to those hospitals described in Appendix to Attachments 3.1A and 3.1B, Section 2a.9a.1, the reimbursement rates described in ~~1-b.iii.B.~~ 1.b.iv. above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

- A. The reimbursement rates described in ~~1-b.iii.B.~~ 1.b.iv. above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
- B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

07/98 viii. Hospitals described in Appendix to Attachments 3.1A and 3.1B, Sections 2a.9a.1 and 2a.9a.2, shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.

TN # 98-14APPROVAL DATE OCT 26 1999EFFECTIVE DATE 07-01-98

Supersedes

TN # 95-23

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

- 07/95 c. Payment for outpatient end-stage renal disease treatment (ESRDT) services shall be:
- 07/95 i. At the rate established by Medicare pursuant to 42 CFR 405, Subpart U (1994).
- 04/93 ii. With respect to Illinois county-owned encounter rate hospitals, the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:
- 07/95 A. The reimbursement rates described in this section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.
- B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 07/93 iii. With the exception of the retrospective rate adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1.d: c.
- 07/95 iv. County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

TN # 98-14APPROVAL DATE OCT 26 1999EFFECTIVE DATE 07-01-98

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TN # 95-23